ROLES AND RESPONSIBILITIES OF TITLE I PLANNING COUNCILS

TECHNICAL ASSISTANCE CONFERENCE CALL

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Arranged by:

Division of HIV Services
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Report prepared by:
Emily Gantz McKay and Cristina López
MOSAICA
The Center for Nonprofit Development and Pluralism
1000 16th Street, N.W.
Suite 604
Washington, DC 20036
(202) 887-0620

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EXECUTIVE SUMMARY

This report summarizes information presented in "Roles and Responsibilities of Title I Planning Councils," the eighth in a series of nationally broadcast technical assistance telephone conference (teleconference) calls arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). This summary reflects both the content of the presentations and the questions from listeners during the call. The teleconference call was broadcast on December 6, 1995. Participating were more than 80 sites nationwide, including more than ten planning councils, 50 Title I and Title II grantees, and at least 20 provider agencies.

The purpose of the teleconference call was to state, clarify, and discuss the roles and responsibilities of planning councils authorized through Title I of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Discussion focused on legislative, DHS, and community expectations for planning councils; the challenges faced by planning councils; and the various roles and responsibilities of planning councils, including both their legislatively mandated tasks and the activities they carry out in collaboration with the grantee and other entities.

Title I planning councils play a critical role in the continuum of program activities and decision making. They are expected to fulfill three legislative mandates: to develop a comprehensive plan, establish priorities for the allocation of Title I funds, and assess the efficiency of the administrative mechanism in rapidly allocating funds to areas of greatest need. In carrying out their responsibilities, they face some significant challenges. Each council is responsible for developing a comprehensive plan for HIV care which typically covers a broad geographic area and diverse population groups. It is expected to identify, recruit, and retain a broadly representative membership of volunteers, who are expected to make a considerable time commitment so they can carry out a set of complex tasks over a brief period with very limited resources. The reauthorization is expected to place additional demands on councils.

DHS has clear expectations for planning councils. It expects them to have membership which is broadly representative of the community and particularly the HIV epidemic in the community. According to DHS Policy #1, at least 25% of members must be people living with HIV disease. In their operations, DHS expects planning councils to have and to follow clearly established bylaws and procedures, to provide orientation and training to their members, and to engage in a comprehensive and broadly inclusive planning process. Planning councils should be autonomous decision-making bodies, planning entities which exist not only to set priorities for the use of Title I funds, but also with broad responsibility for planning for the HIV service needs in their communities. Communities also have expectations for planning councils; most important, they expect the planning process to lead to improved access to care for people with HIV disease and the development of a system of care.

The differing roles and responsibilities of planning councils and grantees require careful clarification. In addition to carrying out their legislative mandates, planning councils are expected to work collaboratively with the Title I grantees to conduct a needs assessment. They

are expected to set service priorities, but not to become involved in the designation or selection of particular entities as recipients of Title I funds. While individual council members may be involved in procurement activities, participation must be free of any real or perceived conflict of interest where planning council members have a financial stake or relationship to any entity being considered as a recipient of Title I funds. Planning councils can become involved in program evaluation along with the grantee.

Many factors can contribute to -- or impede -- the ability of planning councils to successfully carry out their mandated tasks and collaborative activities. An important challenge is **membership** -- how to meet legislative requirements and secure a diverse membership which reflects the local epidemic, with emphasis on persons living with HIV/AIDS (PLWH), minority, and geographic representation. Another ongoing challenge is how to manage the inherent **conflict of interest** within planning councils, which are expected to bring together those who are the most knowledgeable about HIV/AIDS services and service needs and still avoid situations in which individuals will make decisions that have financial benefits for themselves and their organizations. A third major challenge is how to manage the **conflicts** which inevitably occur in a collaboration among equals -- government agencies, community-based organizations, and members from infected and affected communities. Planning councils need to take steps to reduce and manage conflict, including developing groundrules which can be used to address conflict when it occurs.

DHS has identified several "dual role" situations which can complicate planning council functions. Staff who work for both the grantee and the planning council may perform administrative work for the grantee and provide staff support to the planning council, thus working partly for each entity. Because one of the planning council's legislative mandates is to evaluate the grantee's administrative mechanism, this dual role could compromise the objectivity required to carry out this task. Consideration needs to be given to split supervision and evaluation of performance, especially if local payroll mechanisms are being used. A related complication can occur if the principal grantee contact serves as chair or co-chair the planning council. CARE Act reauthorization may specify that an employee of the grantee may not be the sole chair of the planning council. Based on years of program experience, DHS further advises against the grantee contact being a co-chair, because it is not appropriate for the Title I grantee contact to functionally perform the duties related to the planning council's three legislative mandates. Keeping personnel separate helps keep grantee and planning council roles separate.

A wide range of technical assistance is available to planning councils. This ranges from consultation with their EMA's Project Officer to consultant assistance through the DHS technical assistance contract with John Snow, Inc., use of DHS technical assistance materials and its newsletter, *CAREnotes,* and advice and assistance from other planning council representatives.

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I. INTRODUCTION

A. PURPOSE

This report summarizes the information presented in **"Roles and Responsibilities of Title I Planning Councils,"** the eighth in a series of nationally broadcast technical assistance telephone conference (teleconference) calls arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). Included in the summary are both the content of the presentations and the questions and comments from listeners during the call. The teleconference call was broadcast on December 6, 1995.

The purpose of the teleconference call was to state, clarify, and discuss the roles and responsibilities of Title I HIV Health Services Planning Councils. Included were legal requirements as specified in the current legislation and expected changes in the reauthorization, DHS expectations and the importance DHS places on fully functioning planning councils, and community expectations for planning councils.

The teleconference included panelists from the DHS and consultants who have worked extensively with planning councils. (See Appendix A for a list of panelists, with contact information and Appendix B for the agenda.)

B. PROCESS

Like the other teleconference calls in this series, the teleconference addressed topics and questions submitted by CARE Act grantees, planning council members, and HIV/AIDS service providers. In addition, listeners had an opportunity to ask questions during the call. Participating in the teleconference call were more than 80 sites nationwide, including more than ten planning councils, 50 Title I and Title II grantees, and at least 20 provider agencies.

The format for this conference call included a significant amount of commentary from the Division of HIV Services, to describe both the legal requirements for planning councils and the importance the Division places on this topic. Due to the diversity of participants and the varying degrees of planning council experience, included were some basic principles related to planning councils. Questions submitted along with participant registration were used to help develop the agenda.

II. REAUTHORIZATION STATUS AND IMPLICATIONS

Reauthorization of the CARE Act is showing some movement. A reauthorized CARE Act bill has been passed in both the House and Senate. While a conference to reconcile the different provisions in the two bill has not been scheduled, both the House and the Senate have now appointed conferees, and House and Senate staff have been working together on a number of

provisions where there are differences between the two bills. Because the House leadership has set budget reconciliation as a priority, it has been postponing House activity on a broad range of authorization activities, not just the Ryan White CARE Act. Without reauthorization, the program is operating under the original CARE Act statute.

A budget reconciliation agreement has yet to be reached between the Congress and the White House. At the time of the conference call, many agencies of the federal government were operating on a continuing resolution that provided partial funding and authorization for continued operations until December 15, 1995. It was expected that an additional continuing resolution would be required to carry the government until the budget reconciliation process was completed, or else parts of the government, including most CARE Act staff, would once again be furloughed. That furlough did occur, and ended in January with a second continuing resolution. However, no final budget agreement had been reached as of mid-February.

The current situation has important implications for the Title I and Title II programs. As formula budget periods become due for Title I grantees, DHS will provide partial funding to carry projects over for several months, and will issue as many partial awards as are needed and as funds are available, until full-year funding is achieved. However, new Title I eligible metropolitan areas (EMAs) will not be able to receive partial funding under the formula application until the budget situation is resolved; it is not possible under a continuing resolution to make new awards to newly eligible EMAs. A year-long funding mechanism must be in place, whether that is a year-long continuing resolution or a full appropriation. Once this year-long funding mechanism has been agreed to, DHS will be able to provide funding to newly eligible EMAs even in the absence of a reauthorized CARE Act.

III. PLANNING COUNCIL ROLES AND EXPECTATIONS

Title I HIV Health Services Planning Councils play a critical role in the continuum of activities and decision making that occur within the program. All the current Title I EMAs have working planning councils which can point to a variety of achievements. They also face some considerable challenges (See box, next page).

Each planning council is responsible for developing a comprehensive plan for HIV care services which typically covers a broad geographic area and includes diverse population groups. To carry out its difficult and complex planning tasks, it is expected to identify, recruit, and retain a broadly representative membership, and these

PLANNING COUNCIL CHALLENGES

- Very broad representation
- Complex planning tasks
- Considerable time commitment
- Demanding timeframes
- Broad geographic area
- Diverse populations
- Limited resources

volunteers are expected to make a considerable time commitment. The timeframes for completing this work are very demanding, and resources are limited. Challenges are likely to grow in the future, due to new requirements in the reauthorization and the likelihood that funds will not be growing commensurate with the local growth in the epidemic.

Expectations for planning councils come from three sources: the law, the Division of HIV Services which is responsible for administering the program nationally, and the community. These expectations and their practical implications are described below.

A. LEGISLATIVE MANDATES AND EXPECTED CHANGES

The current CARE Act legislation specifies three legislative mandates for planning councils -- three major tasks which all Title I planning councils are expected to complete:

LEGISLATIVE MANDATES FOR PLANNING COUNCILS

1. To develop a comprehensive plan compatible with existing state and local plans for HIV health services.

2. To establish priorities for the allocation of funds within the EMA.

3. To assess the efficiency of the administrative mechanism in rapidly allocating funds to areas of greatest need.

While the chief elected official within each EMA has the authority to designate and establish planning councils, they were not intended to be advisory bodies. They are to be given discretion in executing the three mandated responsibilities. The statute provides very clear requirements about who needs to serve on planning councils and what councils need to do, and also addresses some other tasks that are less clearly specified and need to be handled locally.

Under the expected reauthorization of the CARE Act, expectations for planning council functioning will increase (see box). Besides expanded membership and representativeness requirements, planning councils will be expected to provide increased accountability for the overall planning process, emphasizing elements such as cost effectiveness and a clear delineation of how the planning council moves from needs assessment results to priority setting. Planning councils will also need to address special service needs such as those that may result from the implementation of ACTG 076 to prevent perinatal transmission of HIV. In all their work, planning councils will be expected to improve management of the complex problem of conflict of interest.

EXPECTED CHANGES IN PLANNING COUNCIL FUNCTIONING DUE TO REAUTHORIZATION

- Increased categories of membership
- Increased focus on the representativeness of planning council members
- Increased accountability for the overall planning process
- Stated priorities for specific populations and service needs
- Better management of the conflict of interest challenge

B. DHS EXPECTATIONS

DHS believes that planning council functioning is the core of effective Title I implementation, and has clear expectations related to planning council roles, membership, and operations.

DHS expects that planning councils will be broadly representative of the community and particularly of the HIV epidemic in the community. The first written policy from DHS (Policy #1) requires that a minimum of 25% of planning council members be people living with HIV/AIDS.

DHS EXPECTATIONS FOR PLANNING COUNCILS

- **Membership:** broadly representative
- **Operations:** based on established bylaws and procedures, member orientation and training, and a broadly inclusive planning process
- **Role:** Autonomous decision-making entities which do broad planning for HIV service needs

In their operations, the Division expects planning councils to have and to follow clearly established bylaws and procedures, to provide orientation and training to their members, and to engage in a comprehensive and broadly inclusive planning process. The bylaws should address conflict of interest and provide for a grievance process.

DHS expects planning councils to be autonomous decision-making bodies. It sees them as planning bodies, existing not only to set priorities for the use of Title I funds, but also with broad responsibility for planning for the HIV service needs in their communities.

C. COMMUNITY EXPECTATIONS

Communities also have expectations for planning councils. Communities expect planning councils to work in partnership with the Title I grantee and with the community; this requires a clear understanding of the roles of all the partners. The community also expects that the planning process will generate positive outcomes, including improved access to care for people with HIV disease and the development of a system of care.

D. COST CATEGORIES FOR PLANNING COUNCIL SUPPORT

Title I planning councils may use a reasonable and necessary portion of their grant award to pay for allowable planning council support activities. These allowable costs fall into six categories, as shown in the box. In addition to staff support costs, planning councils may pay costs incurred by members as a result of their participation on the council or in the conduct of council activities -- from transportation and child care to mailing and faxing of materials. Planning councils may also pay the reasonable and necessary costs of conducting a needs assessments, developing a comprehensive plan, and assessing the efficiency of the administrative mechanism. Also allowable are reasonable and necessary marketing activities associated with publicizing planning council activities and programs and efforts to substantively involve the community.

ALLOWABLE PLANNING COUNCIL SUPPORT COSTS

- Staff support costs
- Member costs
- Needs assessment costs
- Costs associated with the development of a comprehensive plan
- Costs of assessing the efficiency of the administrative mechanism
- Marketing activities costs

E. APPLICATION GUIDANCES

Planning council responsibilities are addressed throughout the supplemental grant application. They are spelled out most specifically in section two, entitled "Planning Council Functioning," in the application for continuing EMAs, which is worth 15 points, and "Planning Council Capacity to Meet Legislative Mandates," in the new Fiscal Year 1996 EMA Application, which is worth 18 points. This section emphasizes two major areas: the composition of the planning council and how the planning council functions.

Two specific aspects of the composition of the planning council are included:

- Legislatively mandated membership categories; and
- Representation of PLWHs and the 25% policy requirement from DHS.

How the planning council functions is addressed through two major topic areas in this section:

- **Resources** that support planning council activities, including the following:
  - ♦ Indicated support from the chief elected official and the grantee;
  - ♦ Personnel resources, both CARE Act and others, and if employed by the grantee, how those personnel are accountable to the planning council;
  - ♦ Non-personnel resources such as consultants and training and support for PLWHs who participate on the planning council; and
- **Logistics**, including the following:
  - ♦ Bylaws which describe the roles and responsibilities of the planning council, the chief elected official of the EMA, and the grantee;
  - ♦ A copy of the bylaws and checklists; and
  - ♦ The structure of the planning council in terms of committees and subcommittees.

Planning council functions are also emphasized in other grant application sections, including the section which addresses needs assessment, priority setting, and allocation of funds by service priority areas.

IV. PLANNING COUNCIL AND COLLABORATIVE RESPONSIBILITIES

Just as a continuum of HIV care services comes to mind when considering the Title I program, a continuum of activities and decision making occurs within the program itself. Certain activities are the responsibility of the planning council, others belong to the

INDIVIDUAL AND COLLABORATIVE RESPONSIBILITIES OF PLANNING COUNCILS AND GRANTEES

- Planning Council Establishment, Maintenance, and Support
- Needs Assessment
- Preparation of a Comprehensive Plan
- Priority Setting
- Procurement of Services
- Assessing the Administrative Mechanism
- Program Evaluation

grantee, and some areas of joint responsibility require a partnership effort between the planning council and grantee. These activities are summarized in the box and described below.

A. ESTABLISHMENT, MAINTENANCE AND SUPPORT OF PLANNING COUNCILS

The establishment, maintenance, and support of planning councils are necessary to carry out CARE Act mandates. The chief elected official (CEO) of the Title I eligible metropolitan area (EMA) is responsible for establishing or designating a planning council, and must give priority to existing entities with experience in HIV care planning. Once the planning council is established, its membership must be sustained, nurtured, and possibly modified over time to respond to the changing face of the local epidemic and to changes in legislative or programmatic requirements. The planning council's bylaws should include a nominations process, developed in agreement with the CEO, who retains ultimate authority to appoint planning council members. The nominations process should be open and based on locally determined and publicized criteria, while including legislatively specified categories of membership.

Planning councils may use a reasonable and necessary portion of their total Title I formula and supplemental grant funds to finance allowable support activities. Decisions regarding use of funds must be made in conjunction with the planning council's priority-setting process and justified in the budget revision submitted to DHS as a condition of the supplemental grant award. Such funding is distinct from the 5% administrative allocation available to grantees.

B. NEEDS ASSESSMENT

Conducting a comprehensive needs assessment is a partnership activity. Needs assessment activities include the planning council and its members, the grantee, people from the community, especially people with HIV and AIDS, service providers, and other legislatively mandated groups. Ultimately, the product of a community-based needs assessment is used by the planning council to set service priorities and develop a comprehensive plan. However, the Title I grantee is responsible for reporting to DHS on its needs assessment activities, usually as part of its supplemental application or quarterly reports.

C. PREPARATION OF A COMPREHENSIVE PLAN

The first legislative mandate for planning councils is the development of a comprehensive plan compatible with existing state and local plans for HIV health services. The comprehensive plan for HIV care is subject to input and suggestions from a variety of entities that have expertise or knowledge of different population groups and issues related to HIV/AIDS. This may include the Title I grantee, community representatives, health planners, and others. But, ultimately, the comprehensive plan is the responsibility and product of the planning council, and the council maintains authority over the plan.

The comprehensive plan developed by the planning council serves as the guiding light for the EMA in developing a continuum of HIV care. Five basic steps to assist Title I EMAs and Title II areas in conducting effective comprehensive HIV services planning are summarized in the box.

STEPS IN COMPREHENSIVE PLANNING

1. Discuss the planning process and develop a clear written statement about the purpose of planning.
2. Develop a structure for planning.
3. Develop a process for planning that involves all parties.
4. Develop a plan to plan.
5. Implement the plan.

Planning Councils should begin by discussing planning and developing a clear written statement about the purpose of planning for their EMA; this is the first step in the planning process. This statement can be part of the planning council mission statement, bylaws, operating guidelines, or procedures. Planning councils may wish to go a step further and develop a vision or value statement about the plan or the planning process itself. For example, in California, the Title II planning group has a vision and values committee that is developing such a statement as the comprehensive plan is developed.

The second step in comprehensive planning is to develop a structure for planning within the council. Establish a planning committee of the planning council as an *ad hoc* or a standing committee, engaging anywhere from four to 15 people. In St. Louis, Missouri, a comprehensive planning committee of the planning council spearheaded the development of the EMA's plan to plan. Make sure the planning committee includes people with HIV infection and persons who have a special interest in planning. It is important that the planning committee be as diverse as the council.

Third, develop a process for planning that outlines the roles and responsibilities of all groups and individuals involved -- the planning council, the planning committee, planning council staff, the grantee, and health department staff, any consultant(s) you may be working with, and other people in the community. For example, in California's Riverside/San Bernardino EMA, early agreements about who would do what in their comprehensive planning process helped the planning group get off to a good start. Some of these agreement have been renegotiated during the year the group has been working together.

Fourth, develop a plan to plan. It is crucial to develop a plan for your comprehensive planning process that lays out tasks, timelines, and responsibilities, and identifies task leaders and,

in some cases, team leaders. Make sure you follow this plan to carry out the major tasks of planning.

The fifth and last step is to put the plan into action. At each phase of the planning process, be sure to use planning information to help the planning council make decisions about service priorities, resource allocation, and other critical service delivery issues. Remember that planning is about helping the planning council make better decisions about serving people with HIV/AIDS, improving access to a system of care, and creating a continuum of services.

DHS provides guidance on how to organize a comprehensive plan. The sample outline or table of contents included as Attachment II in the Fiscal Year 1995 Title I supplemental application identifies three major sections to a comprehensive plan (see box). Using these three major sections and identifying the tasks needed to generate each type of information -- for example, an epidemiologic profile of the current local epidemic or needs assessment data -- will help ensure a complete and well-structured plan. This approach has been used very effectively in San Francisco to develop a five-year client-centered comprehensive plan.

OUTLINE OF A COMPREHENSIVE HIV SERVICES PLAN

A. Where we are

- Current local epidemic and future trends
- Results of needs assessment
- Inventory of local, state, and federally funded public/private resources in area
- Description of existing continuum of care
- Description of existing barriers to care
- Issues which impact the delivery of services in EMA

B. Where we are going, and how we will get there

- Shared values that will guide development and delivery of HIV services
- Vision of what community expects to achieve with respect to HIV services
- HIV services goals/objectives

C. Monitoring our progress

- Progress towards goals and objectives
- Mechanisms for assessing changes in epidemic, unmet needs, and locally available resources
- Use of data to revise comprehensive plan

D. PRIORITY SETTING

Prioritization of services to be funded under Title I and allocation of resources across service priorities is the second legislative mandate of planning councils. Allocation of resources across priority services can be accomplished via absolute dollar amounts or percentages

of formula and supplemental dollars across service categories. Either way, this responsibility must be assumed by the planning council. To establish service priorities without resource consideration does not meet the mandate of establishing priorities for the allocation of funds within the EMA.

Methods of priority setting vary and include several objective methods that are referenced in annual application guides; three of these are summarized in the box below. Prioritization of services can be targeted very specifically to certain special populations and/or geographic or underserved areas. Priorities, however, must be consistent with locally identified needs and should consider issues such as cost effectiveness; these directives will be referenced in new CARE Act reauthorization language. Planning councils must re-examine their priorities every year. Continuation of current services is not in and of itself a priority.

EXAMPLES OF DECISION-MAKING AND PRIORITY-SETTING METHODS

- **Nominal Group Process:** in small groups, participants consider a question, and write down responses without interaction; responses are elicited in a round-robin fashion; participants first vote for a number of top priorities, then rank them in order of importance. A summation of votes determines top-ranked priorities.

- **Delphi Method:** involves mailing a series of questionnaires to the membership of a decision-making body. The first questionnaire would provide an open-ended format so participants can indicate top-priority service needs; a second questionnaire to the same group would provide collated categories from responses to first questionnaire and ask that they be ranked; a third questionnaire would provide initial vote and comments, and ask for a final ranking.

- **Aggregate Score Sheets:** involves ranking preferences for service priorities; the results are aggregated to establish average scores for each priority area.

The responsibility of priority setting is distinct from the procurement of services and distribution of funds to service providers. As an entity, the planning council has no role in the designation or selection of particular entities as recipients of Title I funds. In some smaller EMAs, discussions about service priorities may, in fact, mean identifying the agencies that are in a position to provide such services simply because there are only one or two service provider agencies in the area. This is understandable and allowable as long as the prioritization process focuses on those services that are responsive to identified needs.

E. PROCUREMENT OF SERVICES

Procurement of services is a responsibility of the grantee and the administrative agent. This responsibility may be delegated to a fiduciary agent. However, the grantee ultimately

remains responsible for this activity, which is considered to be an administrative cost. Procurement of services may include the development and issuance of Requests for Proposals (RFPs), conducting technical assistance and bidder's conferences, conducting the review process, negotiating contracts, and awarding funds. Individual members of planning councils may be involved in procurement activities if they have programmatic or administrative expertise. However, participation should be free of any real or perceived conflict of interest where planning council members have a financial stake or relationship to any entity being considered as a recipient of Title I funds.

Planning councils are not to be involved in approving the amounts to be awarded to individual agencies. The grantee does have a responsibility, however, to communicate back to the planning council the results of procurement process in order to ensure consistency with stated service priorities and allocations. Procurement processes may be completed with results that are inconsistent with planning council priorities. This possibility needs to be addressed proactively in a memorandum of understanding between the grantee and planning council, providing feedback mechanisms regarding the results of the procurement process. In cases where the results are perceived to be inconsistent with identified priorities, it may be necessary for the council to provide specific feedback to the grantee about such differences and the need to reconsider the procurement process.

The reauthorization legislation is expected to directly address the issue of roles and responsibilities related to disbursement of funds. DHS expects to develop some written policies around this issue, with an appropriate period for comment from the grantee and planning council community. DHS considers this separation of roles and responsibilities extremely important, and is especially concerned with the conflict of interest which would occur if the planning council were to become involved in disbursing funds to individual entities as opposed to setting service priorities.

F. ASSESSING THE ADMINISTRATIVE MECHANISM

Assessing the efficiency of the administrative mechanism to allocate funds is the third legislative mandate of planning councils. The legislative language is actually a bit confusing in that it uses the word *allocation* to reference what is really the procurement of services. As DHS interprets this legislative responsibility, planning councils are responsible for evaluating the expeditious and efficient disbursement of funds in the procurement of services as performed by the grantee. Thus, planning councils have a responsibility to assess whether there is a timely contracting or procurement process in place.

The expenditure of funds and timely reimbursement of providers is also an area to be evaluated. In a broad interpretation, there is also a responsibility to assess whether funds are disbursed efficiently with consistency to need and identified service priorities. If the planning council finds that the existing administrative agency is not working well in these areas, then it is

the council's responsibility to make formal recommendations to the chief elected official for improvement and change.

Unfortunately, there are relatively few models of formal evaluative processes in this area. Generally, assessments are based on time-framed observations of the timeliness of such processes. Assessing the administrative mechanism for the allocation of funds is an area that will be addressed in future DHS technical assistance activities and HRSA evaluation activities.

G. PROGRAM EVALUATION

Basic program monitoring is a grantee responsibility and an administrative cost. More substantive program evaluation that focuses on improving the delivery of services or the local planning process can be conducted under the category of program support or other local priorities. Such initiatives must be determined to be a priority by the planning council as part of the larger discussion about unmet needs and prioritization of services.

Reauthorization language discusses a potentially mandated role in evaluation for planning councils. Current DHS guidance suggests that program evaluation is an area of joint responsibility between the grantee and planning council. Evaluation activities will often involve the use of external consultants or universities that have evaluation expertise, and these services must be procured and monitored as with any other direct service. Planning council members can be involved in program evaluation activities, along with PLWHs who have expertise in program evaluation.

V. ISSUES AND STRATEGIES

Many factors can contribute to or impede the ability of planning councils to carry out their mandated tasks and collaborative activities. Some key issues and strategies for addressing them are summarized below.

A. MEMBERSHIP

Membership represents a major challenge for planning councils: how to meet membership requirements and secure diversity, with emphasis on PLWH, minority, and geographic representation.

An important first step for a planning council in evaluating the composition of its membership and its ability to accomplish specific goals is to understand its own goals for membership composition. Local communities should begin with mandated categories of the legislation as well as the DHS policy that at least 25% of planning council members be PLWHs. There are also racial, ethnic, and demographic characteristics of the epidemic that should be

reflected on the planning council. Finally, other local factors may need to be considered. (See the box for the core requirements set by Philadelphia.)

SETTING CORE REQUIREMENTS FOR MEMBERSHIP: PHILADELPHIA

Philadelphia recently reorganized its planning council. In addition to the legislated membership categories, the chief elected official and the Commissioner of Health determined that the planning council membership would:

- **Include 50% PLWHs.**
- **Have geographic representation,** since the EMA includes the City of Philadelphia and eight counties in two states.

These were the core requirements for membership.

It is very important that the planning council as a group develop an agreement on what it means to represent a membership category rather than an entity or a vested interest or agenda. This involves some fundamental aspects of group dynamics and team decision making.

Planning councils need to actively promote and attract participation. Once membership goals have been set, the grantee and planning council can work together to obtain applications from persons fitting those categories. Potential applicants can be asked to self-identify the membership categories which they feel they fit. It is also helpful to ask applicants to identify their affiliations, to help manage the conflict of interest challenge. As applications are received, they need to be compared with the goals set out for the planning council. The planning council can then continue to recruit and invite the participation of people who fit these goals. This often involves a "buttonholing" approach, to get people who fit key categories to know about and become a part of the planning council process.

A planning council needs an ongoing, permanent membership committee, in order to secure diversity. This committee can take responsibility for coordinating the nominations and appointment process as well as orientation of new members, ongoing continuous training and support, and the development of the planning council as a decision-making group.

Relationships with other organizations can be helpful in attaining diversity. The planning council can link with national organizations such as the National Association of People with AIDS and national minority organizations. It can establish caucuses or task forces within the EMA to provide institutional membership to the planning council, or work with existing groups which can provide nominations.

Diversity can also be enhanced by inviting and establishing participation in planning council activities from persons who are not full members of the planning council. Individuals may be asked to serve on committees or task forces. For example, committees can actively seek feedback from affected and minority communities on the impact of planning council decisions, and then provide that formal feedback directly to the planning council for its later work.

One of the most important aspects of planning council membership is ensuring the effective participation of people living with HIV disease. This topic was addressed in an earlier conference call. A useful reference for planning councils in increasing PLWH participation on planning councils is the Academy for Educational Development's *Final Report: The Participation of People with HIV In Title I HIV Health Services Planning Councils*, published September 1994 and available from the Division of HIV Services.

B. CONFLICT OF INTEREST

The CARE Act legislation poses the challenge of an inherent conflict of interest for planning councils. They are expected to convene at the local level those people who are the most knowledgeable about services and service needs for PLWHs and still avoid a conflict of interest that will result in people making decisions that have financial benefits for themselves and their organizations. Conflict of interest was a key area of concern in reauthorization discussions, and is perhaps the number one area of concern and complaint with regard to the functioning of planning councils.

Conflict of interest cannot be entirely avoided or eliminated -- the goal should be to manage it better, so that the planning council functions more effectively. The first requirement in managing conflict of interest is to establish bylaws and operating procedures that deal decisively and clearly with the obvious conflict of interest that can occur when members make decisions that have implications for their own self-interest. Bylaws and operating procedures should clarify the planning council's role and ensure that it does not become involved in specific procurement decisions.

Planning councils need to make it clear that planning council members must be prepared to play two different roles:

1. **Serving as advocates for a particular service area, population group, or community** -- providing the representation for which they were selected as planning council members; and

2. **Considering the needs of the entire EMA as part of a planning process addressing broader issues** -- which may require letting go of the narrower advocacy role.

Membership on a planning council is not merely a forum for advocating a single position. While such advocacy is one important role, based on the membership category model of planing councils, members must be able to get beyond this role to plan for a broad geographic area with multiple populations.

Planning councils also need to address potential conflict of interest or the appearance of conflict of interest. This can be partially addressed through the use of a variety of self-monitoring mechanisms. For example, after looking at the results of its needs assessment, a planning council can clearly identify how it got from the results to the setting of priorities. This review process lets a planning council understand the mechanisms it used and ensure that they were appropriate and free of actual or potential conflict of interest. The planning council can also establish for itself a set of "red flags" to look for in monitoring to avoid conflict of interest. For example:

- **Are most of the service providers who get funding represented on the planning council?** If you are in a situation where nearly all the planning council members who are service providers end up with funding and none of the service providers who are not represented on the planning council get funding, that should be a "red flag" that you may be in a conflict of interest situation.

- **Is there serious community dissatisfaction with your plan or priorities?** If you have gone through the entire planning process and there is broad community dissatisfaction with the results, this should be a "red flag" suggesting possible conflict of interest.

Effective participation of PLWHs serves as a valuable barometer of conflict of interest on a planning council. For example, a planning council can check to see how the priorities brought to it by a PLWH caucus or PLWH members relate to the final priorities set by the planning council. If there are very large gaps, conflict of interest may be the cause.

C. MANAGING CONFLICT

Planning councils must address the issue of conflict, conflict management, and conflict resolution. A key question is what happens when planning council members -- participants in a public-private collaborative partnership -- don't agree on their roles and responsibilities. Does any one entity in this collaboration have the authority or power to make the final decision when there is disagreement among participants? There is no easy answer. Planning councils are truly a collaboration of equals -- government agencies, community-based organizations, and members from the infected and affected communities. The planning council has authority and responsibility, and also needs to assume accountability for dealing with conflict. There will always be disagreement, in the form of conflict, competition, turf battles, and hidden agendas. They are inherent in the process, just as conflict of interest is inherent. The question is how best to manage them.

Planning councils can take a number of preventive steps to reduce and manage conflict. Some hints are summarized in the box. One of the most important is to clarify roles and responsibilities in writing to all participants, at each stage of the development of the planning council; planning councils should write down what they need to do. Then they can decide who is going to do it; this means developing written statements that document the commitments expected from each planning council member. Also ask every member, in writing or in a facilitated meeting, what s/he needs from the planning council. We know that members bring expertise to the table, but the planning council also serves to meet its members' needs. A planning council should encourage members to be "up front" about their needs; this avoids hidden agendas.

HINTS FOR MANAGING CONFLICT

- Clearly delineate roles and responsibilities in writing to all participants.
- Develop written statements that document the commitments expected from each participant.
- Encourage members to be up front about their needs.
- Make clear communication a priority.
- Don't avoid conflict.
- Develop up-front groundrules for conflict management.

Most conflict situations result at least partly from a lack of clear communication between leadership and members, between the grantee and planning council, between the general community and the planning council, or between the committees and the planning council membership. It is important for clear communication to be made a priority, and for all members to be communicated with regularly -- with no assumptions that everyone already knows what is going on. The communication loop should include the general community.

Planning councils should not avoid conflict such as turf issues or hidden agendas. During at least one forum a year, everyone should have the opportunity in a safe, facilitated way to talk about their boundaries -- what they do, what they are trying to do, whom they serve, whom the community thinks they serve, where there is competition, where there is overlap and duplication. This leads to a common understanding of these issues.

It helps to develop groundrules for conflict management before the conflict occurs. When conflict or disagreement occurs which does not appear to be easily resolved, implement these groundrules. Entities which use them often manage to deal with conflicts without the situation becoming divisive. The box provides some sample groundrules.

SAMPLE GROUNDRULES FOR CONFLICT MANAGEMENT

When conflict occurs:

- Stop your process and clarify the key interests and needs of the people in conflict, and then write a list of alternatives.
- Stop the agenda and brainstorm creative options.
- Give every participant the opportunity to speak, and set aside enough time to try to resolve the conflict.
- Always assume that a negotiated "win-win" is possible.
- Do not allow personal attacks.
- Get outside help when a deadlock happens.
- Recognize that planning council members have to confront each other's differences before they can start performing as a team.

Preventive measures greatly reduce disruptive conflict. Prepare governance documents, memoranda of understanding, grievance procedures, and job descriptions "up front." The more planning councils define all their processes, write them down, and distribute them to all members, the less disruptive conflict will be.

D. DUAL STAFF ROLES

Staff who work for both the grantee and the planning council face special challenges. Because of limited funds, Title I EMAs often have staff who perform administrative work for the grantee and also provide staff support to the planning council. The key challenge in such situations is the distinct but interrelated functions that such staff perform. A related complication is that one of the legislative mandates for planning councils is to assess the grantee's

administrative mechanism. Staff models that involve a dual function have the potential to compromise the objectivity needed to carry out this task.

Staff are most likely to have dual responsibilities where the EMA supports the work of the planning council either out of the 5% administrative costs permitted under the grant or through other local funds. Such EMAs do not use additional Title I funds for planning council support because they wish to maximize the amount of Title I funds available for direct services. Situations have also occurred in which administrative costs have been "hidden" in Title I planning council support budgets rather than included in the permitted 5% administrative costs; this is in violation of the legislation and does not contribute to the fullest support of direct health care and support services.

Where staff roles are divided between the grantee and the planning council, the Title I contact and planning council chair need to clearly agree to and understand the division of labor and responsibilities. The planning council should have the opportunity to select the staff or resources for the work to be done for the planning council. Grantees and planning councils should address this issue early on, especially if the local jurisdiction's hiring or contracting mechanisms are to be used to select personnel or contractors.
Consideration needs to be given to split supervision and evaluation of performance, especially if local payroll mechanisms are being used. It is incumbent upon the EMA to clearly define staff functions and provide for separation of assignments and responsibilities. The two sets of functions should be costed out to reflect the time and effort required, and this information should be included in budget justifications. Lines of communication and reporting should be clearly delineated, so that administrative activities are reported to the grantee's principal contact and planning council support activities are reported to the planning council chairperson, a designated council committee, or the full council.

E. GRANTEE-PLANNING COUNCIL RELATIONSHIP

The grantee and the planning council must work closely together, but have distinct roles and responsibilities. Having the grantee contact serve as chair of the planning council greatly complicates this relationship. Reauthorization discusses the fact that the grantee contact may not be the sole chair of the planning council. Based on years of program experience, DHS further advises against the grantee contact being even a co-chair of the planning council. This is because it is not appropriate for the Title I grantee contact to functionally perform the duties related to the planning council's three legislative mandates. For example, one of these mandates is to evaluate the grantee's administrative mechanism. A co-chair who works for the grantee might be in the position of helping to evaluate for the planning council the work s/he has helped perform as grantee staff, which could compromise the objectivity of the evaluation process.

Keeping personnel separate helps keep roles separate. For example, the principal grantee contact might provide expert advice and leadership on developing a comprehensive plan for the provision of HIV care in the EMA. However, the grantee contact must not take a

leadership role in shaping the direction or contents of that plan, since that responsibility, by legislative mandate, rests with the planning council.

F. TECHNICAL ASSISTANCE RESOURCES

A wide range of technical assistance is available to planning councils. At the local level, planning councils can incorporate training activities into their operations; they should provide orientation for new planning council members and offer ongoing training on key issues for all planning council members. DHS offers assistance at several levels, with Project Officers as the first line of communication.

SOURCES OF TECHNICAL ASSISTANCE

- Your DHS Project Officer
- Consultants available through the John Snow, Inc. (JSI) technical assistance contract
- Resources to assist with data collection activities
- Written materials prepared by DHS
- *CAREnotes* newsletter from DHS
- Other planning council members

Project Officers can provide informal telephone consultation and can offer an individual consultant or consultant team through the Technical Assistance Contract (TAC) with John Snow, Inc. (JSI). Consultants recently provided a one-day training session and retreat for planning council members in Jacksonville, Florida. Activities included outlining each planning council member's roles and responsibilities, and development of a work plan for the next year. In Puerto Rico, consultants provided a training session for planning council members in three EMAs to help the planning councils maintain and secure participation of PLWHs; another session focused on roles and responsibilities of planning council members in Caguas and how to develop a needs assessment and comprehensive plan.

DHS has a variety of materials which can assist planning councils. For example, there are reports on other telephone conference calls, and a newsletter, *CAREnotes*, which lists resource materials prepared to help planning councils do their work. Anyone who wishes to receive *CAREnotes* on a regular basis can request it from DHS.

Planning council representatives may find it very helpful to talk to each other. Appendix C provides a list of Project Officers and the grantees with whom they work, along with a listing of all the planning councils.

VI. CONCLUSIONS AND EVALUATION

A. CONCLUSIONS

Title I planning councils play a critical role in the continuum of program activities and decision making, and their responsibilities are likely to be increased under reauthorization. They are expected both to fulfill their legislative mandates and to work collaboratively with the grantee and community on a variety of tasks, which require completion of several complex functions in a short time frame, with limited resources and the commitment of volunteer members.

DHS has clear expectations for planning councils with regard to membership, functioning, and scope of activity. It expects them to have membership which is broadly representative of the community and particularly the HIV epidemic in the community. According to DHS Policy #1, at least 25% of members must be people living with HIV disease. In their operations, DHS expects planning councils to have and to follow clearly established bylaws and procedures, to provide orientation and training to their members, and to engage in a comprehensive and broadly inclusive planning process. Planning councils should be autonomous decision-making bodies, planning entities which exist not only to set priorities for the use of Title I funds, but also with broad responsibility for planning for the HIV service needs in their communities.

Planning councils and grantees have clearly outlined responsibilities, some of which are shared. In addition to carrying out their legislative mandates -- to develop a comprehensive plan, establish priorities, and assess the efficiency of the administrative mechanism in allocating funds -- planning councils should work collaboratively with the grantee to conduct a needs assessment. Although planning councils are expected to set service priorities, they are not to become involved in the selection of recipients of Title I funds. Planning councils can become involved in program evaluation along with the grantee, but basic program monitoring is a grantee responsibility.

Many factors affect the ability of planning councils to successfully carry out their mandated tasks and collaborative activities. An important challenge is membership -- how to meet legislative requirements and secure a diverse membership which reflects the local epidemic, with emphasis on PLWH, minority, and geographic representation. Another ongoing challenge is how to manage the inherent conflict of interest within planning councils, which are expected to bring together those who are the most knowledgeable about HIV/AIDS services and service needs and still avoid situations in which individuals will make decisions that have financial benefits for themselves and their organizations. A third major challenge is how to manage the conflicts which inevitably occur in a collaboration among equals -- government agencies, community-based organizations, and members from infected and affected communities. Dual roles for staff who work partly for the grantee and partly for the planning council also represent a challenge. Related

difficulties can arise where the principal grantee contact serves as the chair or a co-chair of the planning council; DHS notes that keeping personnel separate helps keep roles separate.

All current EMAs have working planning councils, which can point to many achievements. Experience suggests ways to strengthen planning council functions and minimize or overcome major challenges. A variety of technical assistance resources are also available through DHS to assist planning councils.

B. EVALUATION

Participants in each teleconference call are encouraged to complete brief written forms asking for evaluation feedback, suggestions/comments, and recommendations for follow-up. the national CARE Act technical assistance provider for analysis. Twenty-six evaluations were received for this teleconference call; the full evaluation report is included as Appendix D. Major results are summarized below.

Overall, the teleconference received high ratings (3.8 on a scale of 1 to 5). Listeners had especially positive opinions regarding the technical coordination and content of the call. Thirty-eight percent of respondents mentioned the need for a summary report of the conference and suggested possible attachments, including DHS guidelines, sample bylaws and needs assessments, and a list of conference call registrants and speakers. Some respondents suggested future conference call topics, including comprehensive planning, a more in-depth discussion of planning council roles, and conflict of interest.

APPENDIX A:
PANELISTS

FACILITATOR

Jon Nelson, Chief, Planning and Technical Assistance Branch, Division of HIV Services

PANELISTS

Anita Eichler, Director, Division of HIV Services

Steven Young, Chief, Eastern Services Branch, Division of HIV Services

Andrew Kruzich, Deputy Branch Chief, Planning and Technical Assistance Branch, Division of HIV Services

Miguel Gómez, Project Officer, Technical Assistance Contract, Planning and Technical Assistance Branch, Division of HIV Services

CONSULTANTS

Patricia Eleanor Franks, Technical Assistance Consultant to the Division of HIV Services, University of California at San Francisco, San Francisco, California

Matthew McClain, Technical Assistance Consultant to the Division of HIV Services, Philadelphia, Pennsylvania

Donna M. Yutzy, Technical Assistance Consultant to the Division of HIV Services, Sacramento, California

APPENDIX B

AGENDA

Roles and Responsibilities of Title I Planning Councils

Technical Assistance Conference Call
December 6, 1995

I. Introductions

II. Opening Statements
Current Challenges and Increased Expectations
for Planning Council Members

III. Overview of Planning Council Roles and Responsibilities

A. Review of the Three Legislative Requirements
B. Delineation of Planning Council Members' Roles and Responsibilities for the Following Tasks:

1. Establishment, Maintenance, and Support of a Planning Council
2. Needs Assessment
3. Comprehensive Planning
4. Priority Setting
5. Disburse/Contract Funds (Procurement of Services)
6. Assess Administrative Mechanism to Allocate Funds
7. Evaluate CARE Services and Planning Council Functioning

IV. General Questions

A. What is the Status of Reauthorization?
B. What are the Application Guidance Requirements Related to Planning Councils?

V. Questions from Listeners

A. What are Ways to Meet Membership Requirements?
B. How Do You Avoid and Manage "Conflict of Interest"?
C. How Do You Conduct Effective Comprehensive Health Planning?
D. What Happens When Planning Council Members Don't Agree on Their Roles and Responsibilities?
E. What Are the Key Challenges for Planning Council Staff Who Work for Both the Grantee and the Planning Council?
F. What Technical Assistance is Available to Help Planning Councils?
G. Additional Questions from Listeners

APPENDIX C:
LIST OF TITLE I GRANTEES AND PLANNING COUNCIL CHAIRS

Ryan White CARE Act
Title I EMA Contacts

City	Contact Person	Planning Council Chairperson
Atlanta/Fulton County	Kandace Boyd, Assistant Director Ryan White Projects Epidemiology and Prevention Branch Georgia Department of Human Resources 2 Peachtree Street, N.W., 10th Floor, Rm. 400 Atlanta, GA 30303-3 186 404 657-3129 (FAX) 404 730-4754 Kathy Bush Ryan White Projects Epidemiology and Prevention Branch Georgia Department of Human Resources 2 Peachtree Street, N.Ws. 10th Floor, Room 400 Atlanta, GA 30303-3 186 404 657-3129 (FAX) 404 657-3119	James F. Martin Georgia State Representative 44 Broad Street, Suite 500 Atlanta, GA 30303 404 522-0400 (FAX) 404 657-8277
Austin	Pat Feagin Manager, Grants Administration Austin/Travis County Health Department 327 Congress, Suite 500 Austin, TX 78701 512 370-8929 (FAX) 512 370-8935	Karma Crawford Planning Council Coordinator P.O. Box 1088 Austin, TX 78767 512 499-2407 (FAX) 512 499-2617 Tom Sheffield 1715 Valeria Street Austin, TX 787044015 512 441-1169 (FAX) 512 499-2617
Baltimore	Arista Games, M.D. Assistant Commissioner Preventive Medicine and Epidemiology Baltimore City Health Department 303 East Fayette Street, 5th Floor Baltimore, MD 21202 410 396-4438 (FAX) 410 625-0688	John G. Bartlett, (Co-Chair) 720 Ruthland Ave. Ross Bldg., Room 1129 Baltimore, MD 21205 410 955-3150 (FAX) 410 955-7889 Carl Stokes (Co-Chair) Room 516, City Hall 100 North Holliday Street Baltimore, MD 21202 410 396-4810 (FAX) 410 539-0647

City	Contact Person	Planning Council Chairperson
Bergen/Passaic	Catherine Correa Project Director/Ryan White City of Paterson Department of Human Resources 125 Ellison Street, 1st Floor Paterson, NJ 07505 201 881-3394 (FAX) 201 278-3973	Karen Walker Paterson Counseling Center 319 Main Street Paterson, NJ 07505 202 523-8316 (FAX) 201 523-5116
Boston	Richard A. Stevens Assistant Deputy Commissioner Public Health AIDS Services 1010 Massachusetts Avenue, 2nd Floor Boston, MA 02118 617 534-4559 (FAX) 617 534-5358	Lee Swislow Boston HIV/AIDS Health Services Planning Council Cambridge Hospital 1493 Cambridge Street Cambridge, MA 02139 617 498-1212 (FAX) 617 868-3012
Caguas	Eugenio E. Roura-Ortiz, M.D. City Manager for Health and Social Welfare Apartado 907 Caguas, PR 00726 809 743-5410 (FAX) 809-746-6562 Angie Alvarado Ryan White Program Director CDT P.O. Box 907 Caguas, PR 00726 809 286-9560 (FAX) 809 746-6562	Dámaso Torres Vice-President Caguas Health Services Planning Council P.O. Box 5729 Caguas, PR 00726 809 746-2898 (FAX) 746-3440
Chicago	Larry Wolf Ryan White Program Director HIV/AIDS Public Policy and Programs 333 South State Street, 2" Floor Chicago, IL 60604 312 747-8815 (FAX) 312 747-9663	Renslow Sherer, Director Cook County HIV Primary Care Center 1835 West Harrison Street Chicago, IL 60612 312 633-3003 (FAX) 312 633-3002 Andrew Deppe Ryan White Program Director HIV/AIDS Public Policy and Programs 333 South State Street, 2nd Floor Chicago, IL 60604 312 747-9436 (FAX) 312 747-9663
Dallas	Jon R. Cameron Assistant Director Dallas County Department of Human Services 2377 Stemmons Freeway, 2nd Floor Dallas, TX 75207-2710 214 819-1851 (FAX) 214 819-1850	Ruth Nicholson 1917 Melody Lane Garland, TX 75042-8442 214 278-7831 (FAX) 214 2726470

City	Contact Person	Planning Council Chairperson
Bergen/Passaic	Catherine Correa Project Director/Ryan White City of Paterson Department of Human Resources 125 Ellison Street, 1st Floor Paterson, NJ 07505 201 881-3394 (FAX) 201 278-3973	Karen Walker Paterson Counseling Center 319 Main Street Paterson, NJ 07505 202 523-8316 (FAX) 201 523-5116
Boston	Richard A. Stevens Assistant Deputy Commissioner Public Health AIDS Services 1010 Massachusetts Avenue, 2nd Floor Boston, MA 02118 617 534-4559 (FAX) 617 534-5358	Lee Swislow Boston HIV/AIDS Health Services Planning Council Cambridge Hospital 1493 Cambridge Street Cambridge, MA 02139 617 498-1212 (FAX) 617 868-3012
caguas	Eugenio E. Roura-Ortiz, M.D. City Manager for Health and Social Welfare Apartado 907 Caguas, PR 00726 809 743-5410 (FAX) 809-746-6562 Angie Alvarado Ryan White Program Director CDT P.O. Box 907 Caguas, PR 00726 809 286-9560 (FAX) 809 746-6562	Dámaso Torres Vice-President Caguas Health Services Plating Council P.O. Box 5729 Caguas, PR 00726 809 746-2898 (FAX) 746-3440
Chicago	Larry Wolf Ryan White Program Director HIV/AIDS Public Policy and Programs 333 South State Street, 2" Floor Chicago, IL 60604 312 747-8815 (FAX) 312 747-9663	Renslow Sherer, Director Cook County HIV Primary Care Center 1835 West Harrison Street Chicago, IL 60612 312 633-3003 (FAX) 312 633-3002 Andrew Deppe Ryan White Program Director HIV/AIDS Public Policy and Programs 333 South State Street, 2nd Floor Chicago, IL 60604 312 747-9436 (FAX) 312 747-9663
Dallas	Jon R. Cameron Assistant Director Dallas County Department of Human Services 2377 Stemmons Freeway, 2nd Floor Dallas, TX 75207-2710 214 819-1851 (FAX) 214 819-1850	Ruth Nicholson 1917 Melody Lane Garland, TX 75042-8442 214 278-7831 (FAX) 214 726470

City	Contact Person	Planning Council Chairperson
Denver	**Susan Geissler** **Mayor's Office of HIV Resources** Coordination 303 West Colfax Avenue Suite 1625 Denver, CO 80204 303 640-1984 (FAX) 303 640-4627	Martha De Ulibarri **Visiting, Nurses** Association 3801 East Florida Ave., Suite 800 Denver, CO 80210 303 753-7308 (FAX) 303 595-0446
Detroit	Melinda Love Dixon, M.D. Medical Director for Disease Control Detroit Health Department Herman Kiefer Building, Rm. 302C 1151 Taylor Street Detroit, MI 48202 3 13 876-4720 (FAX) 313 876-0177	Victor L. Marsh Office of Federal, State and Municiple Government Relations 5057 Woodward Ave. Detroit, MI 48202 313 494-2217 (FAX) 313 494-1717 Tracy St. Croix TRAPHIC 363 East Glass Road Ortonville, MI 48467 8 10 627-9279 (FAX) 810 627-5941
Dutchess County	Spencer Marks Communicable Disease Section Dutchess County Health Department 387-391 Main Mall Poughkeepsie, NY 12601 914 431-1546 (FAX) 914 486-3447	William E. Arnold P.O. Box 1387 Kingston, N.Y. 12401 202 462-0260 (FAX) 202 462-0446
Fort Lauderdale/ Broward County	Juliette Love Office of HIV/AIDS Support 1323 South East 4th Avenue Ft. Lauderdale, FL 33316 305 765-5364 (FAX) 305 765-5344	James W. Jordan, Jr. North Broward Hospital District 303 SE, 17th Street Attn. Administrator Ft. Lauderdale, FL 33316 305 355-5 120 (FAX) 305 355-4966
Houston	Sue Cooper HIV Services Harris County Health Department 2223 West Loop South Houston, TX 77027 713 4396090 800 579-AIDS (FAX) 713 439-6338 Thomas Hyslop, M.D. Director, Harris County Health Department 2223 West Loop South Houston, TX 77027 713 4396016 (FAX) 713 4396060	King Hillier Harris County Hospital District P.O. Box 66769 Houston, TX 77266 713 746-5410 (FAX) 713 746-5401 King Hillier Federal Express Address Harris County Hospital District 2525 Holly Hall Houston, TX 77054 713 746-6410

City	Contact Person	Planning Council Chairperson
Hudson County/ Jersey City	Carol Ann Wilson, Director Hudson County Department of Human Services 567 Pavonia Avenue, Room 111 Jersey City, NJ 07306 201 795-6933 (FAX) 201 795-0273	Earl Fowlkes (Co-chair) Hyacinth AIDS Foundation Gregory Plaza - Building 7 280 Henderson Street Jersey City, NJ 07302 201 432-l 134 (FAX) 201 4329012
Jacksonville	Virgil S. Green, Chief Mental Health and Welfare Divison City of Jacksonville 623 Beechwood Street Jacksonville, FL 32206 904 630-0825 (FAX) 904 630-0799	Jeanne Ward 220 East Bay Street Jacksonville, FL 32202 904 630-1776
Kansas City	Judy Moore-Nichols AIDS Program Manager Kansas City Health Department 1423 East Linwood Boulevard Kansas City, MO 64109 816 923-2600 (FAX) 816 861-3299	Ann Dey Director of Ryan White CARE Consortium Kansas City Health Department 1423 East Linwood Boulevard Kansas City, MO 64109 816 923-2600 (FAX) 816 861-3299
Los Angeles County	John Schunhoff AIDS Programs LA County Department of Health Services 600 South Commonwealth, 6th Floor Los Angeles, CA 90005 213 351-8001 (FAX) 213 387-0912	Gary Costa, (Co-Chair) c/o Being Alive 3626 Sunset Boulevard Los Angeles, CA 90026 213 667-3262 (FAX) 213 667-2735 Marcy Kaplan, (Co-Chair) Los Angeles Pediatric AIDS Network 6430 Sunset Boulevard, Suite #1003 Los Angeles, CA 90028 213 669-5616 (FAX) 213 461-1394
Miami/Dade County	Daniel T. Wall Project Director Audit and Management Services Dept. 140 West Flagler Street Room 1604 Miami, FL 33130-1561 305 375-4742 (FAX) 305 375-4454	James (Jon) Cullipher 1154 NorthEast 91st Terrace Miami Shores, FL 33138-3404 305 754-3210 (FAX) 756-5419
Nassau/Suffolk	Michelov Rhau Project Director, Title I County of Nassau Department of Health 240 Old Country Road Mineola, NY 11501-4250 516 571-4981 (FAX) 516 571-1691	Theodore Jospe 301 East Main Street Bay Shore, NY 11706 516 968-3001 (FAX) 516 968-3315

City	Contact Person	Planning Council Chairperson
Newark	**Maria Irizarry** Ryan White Unit Coordinator Newark Department of Health and Human Services 110 William Street, 2nd Floor Newark, NJ 07102 201 733-5450 (FAX) 201 733-5444 Marsha McGowan Health Officer, City of Newark Newark Department of Health and Human Services 110 William Street, 2nd Floor Newark, NJ 07102 201 733-7592 (FAX) 201 733-5444	**Terrence Zealand, Ed.** D. (PC Chair) AIDS Resource Foundaton for Children, Inc. 182 Roseville Avenue Newark, NJ 07107 201 483-4250 (FAX) 201 483-1998 Nick Macchione Executive Director Newark EMA Health Services Planning Council 315 North Sixth Street, 2nd Floor P.O. Box 7007 Newark, NJ 07107 201 485-5220 (FAX) 201 485-5085
New Haven	Thomas E. Butcher Director of Health 54 Meadow Street New Haven, CT 06519 203 946-7388 (FAX) 203 946-5953	Dr. George A. Appleby, ACSW Southern Connecticut State University 501 Crescent Street New Haven, CT 06515 203 392-6567 (FAX) 203 392-6580 Jerri Bryant Hill Treatment Services, Apt Foundation Orchard Methadone Clinic 540 Ella Grass Boulevard New Haven, CT 06519 203 78 l-4695 (FAX) 203 781-4700
New Orleans	Barbara Cooper Director of Mayor's Office on Health Policy 1300 Perdido Street, 2E10 New Orleans, LA 70112 504 565-8078 (FAX) 504 565-7921	Beth Scalco Pediatric AIDS Program Children's Hospital 200 Henry Clay Avenue New Orleans, LA 70118 504 524-4611 (FAX) 504 523-2084
New York	Mitchell Netburn Assistant Commissioner New York City Dept. of Health 225 Broadway, 23rd Floor New York City, NY 10007 212 693-1440 (FAX) 212 693-1468 or 212 693-1305	Ron Johnson 52 Chambers Street Room 316 New York, NY 10007 212 788-2762 (FAX) 212 788-9360
Oakland/ Alameda County	Eugene K. Richards, Director Alameda County Health Care Services Agency Office of AIDS Administration 1970 Broadway, Suite 1130 Oakland, CA 94612 510 873-6500 (FAX) 510 873-6555	Gloria Lockett 630 20th Street Oakland, CA 94612 510 874-7850

City	Contact Person	Planning Council Chairperson
Orange County	Penny Weismuller Manager, Disease Control Public Health Grange County Health Care Agency Building #79 1719 west 17th street Santa Ana, CA 92706 714 834-8025 (FAX) 714 834-8196 Ron Taylor Disease Control Public Health Orange County Health Care Agency Building #79 1719 West 17th Street Santa Ana, CA 92706 714 834-8704 (FAX) 714 834-8196	Bob Gentry, Chair Grange County HIV Planning Advisory Council 1475 Pacific Avenue Laguna Beach, CA 92651 714 824-7758 (FAX) 714 824-8153
Orlando	Lisa Nason Assistant to the Chairman Orange County Chairman's Office 201 South Rosalind Avenue Orlando, FL 32802 407 836-7370	Gidgett Russetta Manager, HUG-ME Protram Suite 303 85 West Miller Street Orlando, FL 32806
Philadelphia	Mr. Jesse Milan, Jr., Esq. Director AIDS Activities Coordinating Office Philadelphia Department of Public Health 500 South Broad Street Philadelphia, PA 19146 215 685-6788 (FAX) 215 685-6714	
Phoenix	David Willoughby Program Manager,Title I CARE Services Maricopa County Department of Public Health Services 1845 East Roosevelt Phoenix, AZ 85006 602 506-6858 (FAX) 602 506-6885	David B. Graham Planning Council Chair 112 E. Alvarado Phoenix, AZ 85004 602 253-2200 (FAX) 602 253-2559

city	Contact Person	Planning Council Chairperson
Ponce	Dr. Arturo Torres Aponte (Federal Express) Centro Diagnostico y Tratamiento Valentin Tricoche Oficinas Administrativas Calle Bertoly Esquina Tricoche Ponce, PR 00733 809 842-4302 (FAX) 809 843-5115 Dr. Arturo Torres Aponte (Regular Mail) Hospital Valentin Tricoche Apartado 1709 Ponce, PR 00733 Luis Crux Melendez , (Regular Mail) Programa Ryan White Titulo I Urb. La Rambla Marginal 303 Ponce, PR 00731 809 841-0416	Pedro Castaign Centro Pediatrico Altos Centro Medico Ponce Ponce, PR 00731 809 840-7510 (FAX) 809 840-7510
Portland	Jean Gould Director, HIV/AIDS Services Multnomah County Health Department 426 SW Stark, 8th Floor Portland, OR 97203 503 248-3674 (FAX) 503 248-3676	Susan Stoltenberg, (Co-Chair) Cascade AIDS Project 620 SW 5th, Suite 300 Portland, OR 97204 503 223-5907 x107 (FAX) 503 223-7087 Jerry Walker, (Co-Chair) 121 N.E. 75" Avenue Portland, OR 97213 503 248-5429 (FAX) 503 248-3252
Riverside/ San Bernardino	Thomas J. Prendergast, M.D. Director of Public Health San Bernardino County 351 North Mountainview San Bernardino, CA 92415-0010 909 387-6219 (FAX) 909 387-6228 Marvin Feir Attn: PAS San Bernardino County 172 West 3rd Street, 6th Floor San Bernardino, CA 92415-0010 909 387-6653 (FAX) 909 387-6744	Brad Gilbert, M.D. Director of Public Health Riverside County 4065 County Circle Drive Riverside, CA 92503 909 358-5058 (FAX) 909 358-4529

City	Contact Person	Planning Council Chairperson
San Antonio	Harrison Grindle Bexar County HIV Health Services Program Coordinator 827 North Frio San Antonio, TX 78207 210 224-2437 (FAX) 210 228-0262	Yolanda Cantu (Co-Chair) Community Pediatrics Division University of Texas Health Science Center at San Antonio 7703 Floyd Curl Drive San Antonio, TX 78284-7818 210 692-3641 (FAX) 210 615-0658
San Diego County	Binnie Callender, Chief Office of AIDS Coordination San Diego County Department of Health Services 1700 Pacific Highway, Room 104 San Diego, CA 92101 619 236-2254 (FAX) 619 236-2660	Larry Johnson Associate Director for Planning and Governmental Relations United Way of San Diego 4699 Murphy Canyon Road San Diego, CA 92123 619 492-2079 (FAX) 619 492-2059
San Francisco	Mitchell Katz, M.D. Chief, Health Services Branch AIDS Office San Francisco Department of Public Health 25 Van Ness, Suite 500 San Francisco, CA 94102 (FAX) 415 43 l-7547	Estela Garcia (Co-chair) Instituto Familiar de la Raza 2515 24th Street, #2 San Francisco, CA 94110 415 647-4141 (FAX) 415 647-3662 Norman Dickens AIDS office San Francisco Department of Public Health 25 Van Ness, Suite 500 San Francisco, CA 94102 415 554-9125 Steve Lew 1841 Market Street San Francisco, CA 94103 415 575-3939
San Juan	Sonia Casasnovas (Federal Express) Salud De La Capital, Avenida De Diego Entre La Ama Ey San Francisco Shopping Center AIDS Task Force Rio Piedras, PR 00928 809 751-6075 (FAX) 809 751-9888 Sonia Casasnovas AIDS Task Force P.O. Box 21405 Rio Piedras, PR 00928	Javier Morales, M.D. San Juan Department of Health P.O. Box 21405 Rio Piedras, PR 00928 809 763-6560 (FAX) 809 764-5281
Santa Rosa- Petaluma	Pat Kuta Sonoma County Department of Health Services AIDS unit 499 Humboldt Street Santa Rosa, CA 95404-4214 707 524-7379 (FAX) 707 524-7427	Elizabeth Van Dyke P.O. Box 1357 Guemeville, CA 95446 707 887-l 647 (FAX) 707 887-1440

city	Contact Person	Planning Council Chairperson
Seattle	Theresa Fiano Director, Regional Division Seattle King County Department of Public Health 400 Yesler, 3rd Floor Seattle, WA 98101 206 205-5507 (FAX) 206 2964803	Robert Wood, MD, Co-Chair 2124 Fourth Avenue, 4th Floor Seattle, WA 98121 206 296-2649 (FAX) 206 296-4895 Gregg Johanson, Co-Chair 416 East Roy Street, Unit K Seattle, WA 98102 206 684-8210 (FAX) 206 684-8284
St. Louis	Don Conner, Program Manager Metro AIDS Program City of St. Louis Department of Health and Hospitals 634 North Grand Boulevard, Room 436 St. Louis, MO 63103-2877 314 658-1159 (FAX) 314 658-1045	Bill Dotson City of St. Louis Department of Health and Hospitals Room 812 634 N. Grand Blvd. St. Louis, MO 63103-2877 314 658-1044 (FAX) 314 658-1195 John Holste Planning Council Manager City of St. Louis Department of Health and Hospitals Room 844 634 North Grand Boulevard St. Louis, MO 63103-2877 314 658-1094 (FAX) 314 658-1017
Tampa/St. Petersburg	Alan D. York Hillsborough County Community Health & Human Services Department 601 East Kennedy, 25th Floor Tampa, FL 33602 813 272-5040 (FAX) 813 276-2865	Evelyn V. Smith Director of Case Management Services Planning Council Chair IMPACT 3100 First Avenue North St. Petersburg, FL 33713 813 327-2142 (FAX) 813 323-7549
Vineland/Millville/ Bridgeton	Carmen Bischer Director of Administration Cumberland County Health Department 790 E. Commerce Street Bridgeton, NJ 08302 609 453-2151 (FAX) 609 453-0338	Robert Rougeau Co-Chair HIV Planning Council Social Security Administration P.O. Box 557 Bridgeton, NJ 08302 609 455-2059 (FAX) 609 451-1197 Toni Dangerfield Co-Chair HIV Planning Council Newcomb Medical Center 65 S. State St. Vineland, NJ 08360 609 6919000 ext. 6369 (FAX) 609 794-2439

City	Contact Person	Planning Council Chairperson
Washington, D.C.	Steve Havenner, Chief Division of Patient Services Agency for HIV/AIDS Commission of Public Health 717 14th Street, N.W. Washington, D.C. 20005 202 727-2500 (FAX) 202 727-8471	Ernest C. Hopkins Metropolitan Washington Regional HIV Health Services Planning Council 1133 15th Street, N.W., Suite 1250 Washington, D.C. 20005 202 429-8847 (FAX) 202 835-0118
West Palm **Beach**	**Robert** Bytner, Council Coordinator HIV Services Planning Council C/O Health and Human Services Planning Association 1500 North Dixie Highway, Suite 101 West Palm Beach, FL 33401 407 650-6408 (FAX) 407 650-6102 Edward L. Rich, Director Palm Beach County Dept. of Community Services 810 Datura Street West Palm Beach, FL 33401 407 355-4700	(Mr.) Christy Randazzo Apt.' 2080 1601 South Flagler West Palm Beach, FL 33401 407 833-9522

APPENDIX D:
EVALUATION REPORT

RYAN WHITE TECHNICAL ASSISTANCE CONFERENCE CALL

"Roles and Responsibilities of Title I Planning Councils"

SUMMARY OF PARTICIPANT EVALUATIONS

The eighth conference **call in the** Ryan White Technical Assistance Conference Call Series, "Roles and Responsibilities of Title I Planning Councils", was held on December 6th, 1995. Approximately 100 sites listened to the audioconference, representing over 10 Planning Councils, 50 Title I and II grantees, and 20 Provider Agencies from around the country.

The audioconference relied on presentations from consultants and Division of HIV Services Staff to explain basic principles related to Planning Councils and outline critical information concerning Planning Council roles and responsibilities.

Panelists:

1. Anita Eichler, Director, Division of HIV Services (DHS)
2. Pat Franks, Consultant from San Francisco, CA
3. Miguel Gomez, Project Officer, Technical Assistance Contract, DHS
4. Andy Kruzich, Deputy Director, Planning and Technical Assistance Branch, DHS
5. Matthew McClain, Consultant from Philadelphia, PA
6. Steven Young, Chief, Eastern Services Branch, DHS
7. Donna Yutzy, Consultant from Sacramento, CA

Jon Nelson, Chief of the Planning and Technical Assistance Branch at DHS, facilitated the conference call.

This report is based on twenty-six evaluations that were received from conference call participants. Listeners believe that the call was well-organized and informative. Thirty-eight percent mention the need for a summary report, and suggest possible attachments. Comprehensive planning and conflict of interest emerge as potential future conference call topics.

Overall Evaluation of Conference Call:

1	2	3	x 4	5
Poor		Satisfactory		Excellent

Average *Response:* **3.8**

Listeners regard the technical coordination and content positively, rating the overall conference call 3.8 on a scale of 1 to 5.

Suggestions or Comments Regarding this Conference Call

Twenty percent of respondents believe that the conference call was well-organized and informative. Some suggest that the call should have been longer, to allow for more questions from the audience and to prevent speakers from rushing through presentations. Several feel that the information presented was basic information, and not applicable for older EMAs.
More specific examples would have illustrated certain points.

Random comments and suggestions include the following:

- Excellent format and overall presentation
- Good technical coordination and sound quality
- Thanks to HRSA for explaining their position
- Panelists spoke clearly and slowly
- Use of jargon was low
- The call was too long
- There should have been a Planning Council Staff person on the panel
- Presentations were difficult to follow
- It would have been helpful to mention circumstances when the 25% representation rule can't be met
- Panelists should use fewer urban examples

Recommendations for Follow up to this Particular Conference Call

Thirty-eight percent of respondents mention the need for a summary report of the audioconference. Most important to the report is the inclusion of DHS guidelines, since much of the information presented by DHS regarding Planning Council roles has never been formally communicated to EMAs. Respondents ask for a variety of other supplements to the report, such as sample bylaws and needs assessments, and a list of Planning Council Chairs, conference call registrants, and speakers.

Recommendations for the Content and Organization of Future Conference Calls in this Series

Some respondents suggest future conference call topics. Two listeners ask that comprehensive planning be the focus of an audioconference; two ask that a call address conflict of interest issues; and two suggest an expanded discussion of Planning Council roles. One respondent wants a conference call to provide information on the requirements of the reauthorized CARE Act, and one would like a call to discuss variations in needs assessments -- a comparison of needs assessments from different EMAs.

Others make organizational recommendations. Many respondents convey a sense of appreciation for the conference call series. Several recommend that DHS tackle smaller pieces of a topic at a time, allowing for shorter agendas.

Recommendations include the following.

- Hold two-part calls, with one presentation for newer EMAs and one for more established, knowledgeable EMAs
- Facilitate information sharing across EMAs
- Train speakers in order to to eliminate "um" "uh"
- Send a more detailed agenda in advance